

PERSONAL HEALTH HISTORY

Date: _____ Case No: _____

Name: _____ Email address: _____

Address: _____ City/State/Zip: _____

Date of Birth: _____ Social Security #: _____

Home Phone No: _____ Work Phone No: _____

Marital Status: _____ Cell Phone No: _____

Children's Names and Ages: _____

Name of Employer: _____ Occupation: _____

Hobbies: _____

Referred by: _____

Name of previous Chiropractor(s): _____

When was your last visit? _____

How long were you receiving Chiropractic treatment? _____

Reason for coming in (chief complaint): _____

Are you pregnant? _____ If yes, how many weeks: _____ Due Date: _____ OBGYN / Midwife: _____

What accidents have you had? (i.e. car, sports, slips/falls) at work or at home (include dates): _____

Were you ever knocked unconscious? _____

What fractures or broken bones have you had? (include dates): _____

Surgery: What major surgery have you had? (include dates): _____

What minor surgery have you had? (tonsillectomy, wart/cyst removal, dental extraction) (include dates): _____

Medication:

Present Prescription Medication

Past Prescription Medication

Over-the-counter Medication

_____	_____	_____
_____	_____	_____
_____	_____	_____

Your Birth Record:

Type of Birth: Vaginal Cesarean Other: _____

Any complications during your mother's pregnancy or your birth? _____

Any complications after your birth? _____

Current Health

Please use the following to answer questions below: Poor, Good or Excellent

How would you describe your current health? _____

How would you describe your family's health? _____

Describe your: Vision _____ Hearing _____ Coordination _____

Do you use the following? Tobacco Alcohol Coffee/Tea Milk

Level of stress in your life: Mild Moderate Extreme 1 2 3 4 5 6 7 8 9 10

Do you purchase any of the following? Bottled water Vitamins Health Food

Financial Information

What method of payment will you be using? Insurance Check Cash Credit Card

Who is responsible for this account? _____

Name of Insurance Company: _____ Policy No: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY OR YOU HAVE HAD RECENTLY

- | 1 | 2 | 3 | 4 |
|-----------------------------|------------------------------|---------------------------|-----------------------------|
| A___ Headaches | A___ Fainting | A___ Shortness of Breath | |
| B___ Shooting head pain | B___ Loss of balance | B___ Mid-back pain | A___ Numbness-legs/feet |
| C___ Sinus Trouble | C___ Ringing in ears | C___ Heart Attack | B___ Constipation |
| D___ Loss of smell | D___ Blurred vision | D___ Low blood pressure | C___ Kidney trouble |
| E___ Allergies | E___ Lights bother your eyes | E___ High blood pressure | D___ Menstrual cramps/pain |
| F___ Hay Fever | F___ Neck pain | F___ Anemia | E___ Menstrual irregularity |
| G___ Asthma | G___ Neck muscle spasm | G___ Stomach trouble | F___ Diabetes |
| H___ Loss of taste | H___ Grinding in neck | H___ Nervousness | G___ Sleeping problems |
| I___ Inflammation of throat | I___ Shoulder/arm tightness | I___ Inner tension | H___ Painful joints |
| J___ Thyroid trouble | J___ Shoulder/arm pain | J___ Irritability | I___ Swollen joints |
| K___ Facial Twitch | K___ Pins & needles in arms | K___ Gall bladder trouble | J___ Pins & needles in legs |
| L___ Loss of memory | L___ Pins & needles in hands | L___ Indigestion | K___ Swollen ankles |
| M___ Fatigue | M___ Cold hands | M___ Intestinal gas | L___ Cold feet |
| N___ Depression | N___ Numbness – arms/hands | N___ Low back pain | M___ Pain in legs/feet |
| O___ Dizziness | O___ Swollen tonsils | O___ Hernia | N___ Hip pain |
| P___ Spinal curvature | P___ Prostate trouble | P___ Stroke | O___ Facial pain |
| Q___ Chest pain | Q___ Bed wetting | Q___ Arthritis | P___ Jaw pain (TMJ) |
| R___ Earache | R___ Cancer | R___ Sciatica | Q___ Ulcers |

Office use: _____



TERMS OF ACCEPTANCE

When a person seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has one important goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body’s correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body’s innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body’s innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

CONSENT TO CARE

I do hereby authorize the doctors of HOLLENBACH FAMILY CHIROPRACTIC to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments or any other procedure which is advisable and necessary for my health.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I also understand any sum of money paid under assignment by any insurance shall be credited to my account and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____ have read, understand and hereby request chiropractic care based on the terms of acceptance and the consent to care.

Signature: _____ Date: _____

Consent to evaluate and adjust a minor child (under 18 yoa):

I, _____, being the parent or legal guardian of _____ Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

Parent or Legal Guardian’s Signature

Date

